

WELCOME TO HENRY CHIROPRACTIC

Dr. Grimsley

Grimsley Chiropractic Services, P.C

Dr. Bean

Dr. Hester

22780 Three Notch Road, Lexington Park, MD 20653

Dr. Green

Phone: 301-737-0662 Fax: 301-737-0675

Full Name:	Date:	Circle: M or F
How did you hear about us?	Date of Birth:	Age:
Address:		
City, State, Zip code:		
Home phone:	Cell:	Work:
Employer:	Occupation:	
Name of Spouse:		
Emergency Contact:	Relationship:	Phone:

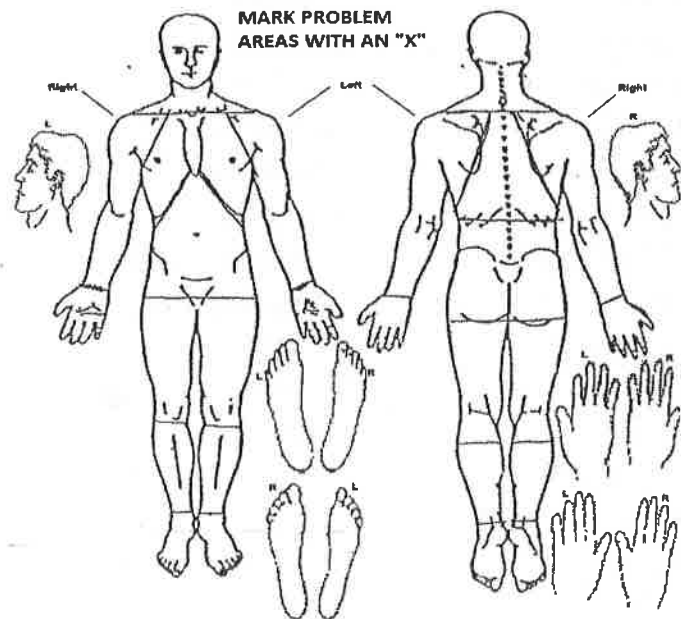
Health Insurance Information

Primary Insurance	Secondary Insurance
Insurance Carrier:	Insurance Carrier:
ID#:	ID#:
Group#:	Group#:
Name of Insured:	Name of Insured:
Relationship: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Relationship: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Insured's DOB:	Insured's DOB:
Insured Employer:	Insured Employer:

I certify that I, and/or my dependent(s) have insurance coverage with & assign directly to GCS, P.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. GCS, P.C. may use my health care information & may disclose such information to the above named insurance companies & their agents for the purpose of obtaining payment for services & insurance benefits or the benefits payable for related services. A photocopy of the Assignment shall be considered as effective & valid as the original.

Signature _____ Printed Name: _____ Date: _____

YOUR CONDITION



Reason for visit: _____

Onset Date: _____

Condition is getting: Worse Better Same

Rate your pain (1=least, 10=severe): _____

Frequency of the pain: _____

Pain interferes with:
 Work Daily Routine Recreation

Pain to perform:
 Sitting Standing Walking Bending Lying

Type of Pain: Aching Burning Cramps Dull
 Numbness Sharp Shooting Stabbing Stiff
 Swelling Throbbing Tingling Other

Health History

What Treatment have you already received for your condition?

Medications Physical Therapy Surgery Chiropractic None Other _____

Name/Facility of Doctor(s) who have treated you for this condition:

Please fill in the dates of your last:

Physical Exam _____
 Spinal X-ray _____
 Blood Test _____
 Chest X-ray _____
 Spinal Exam _____
 CT Scan _____
 MRI _____
 Bone Scan _____

List Location of Lab Work or Radiology Services: _____

Exercise	Work Activity	Habits	PLEASE LIST ALL:
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Smoking	Medications:
<input type="checkbox"/> Moderate	<input type="checkbox"/> Standing	<input type="checkbox"/> Alcohol	_____
<input type="checkbox"/> Daily	<input type="checkbox"/> Light	<input type="checkbox"/> Caffeine	Allergies:
<input type="checkbox"/> Heavy	<input type="checkbox"/> Heavy	<input type="checkbox"/> Stress	_____
			Surgeries, Falls, Broken Bones:

Check if you have had any of the following:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> AIDS/HIV
<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Allergy Shots
<input type="checkbox"/> Anemia
<input type="checkbox"/> Anorexia
<input type="checkbox"/> Appendicitis
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Asthma
<input type="checkbox"/> Bleeding disorder
<input type="checkbox"/> Bladder Disease
<input type="checkbox"/> Bone Disease
<input type="checkbox"/> Bowel Disorder
<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Bulimia
<input type="checkbox"/> Cancer
<input type="checkbox"/> Cataracts
<input type="checkbox"/> Chemical Dependencies | <input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Emphysema
<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Eye Disorder
<input type="checkbox"/> Fractures
<input type="checkbox"/> Gall Bladder Disease
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Gout
<input type="checkbox"/> Headaches
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Herniated Disc
<input type="checkbox"/> Hernia
<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Hypertension
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Liver Disease | <input type="checkbox"/> Low Back Pain
<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Measles
<input type="checkbox"/> Migraines
<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Mumps
<input type="checkbox"/> Nerve Disorder
<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Polio
<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Spinal Disorders
<input type="checkbox"/> Stomach Disorders
<input type="checkbox"/> Stroke
<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Tumors/Growths
<input type="checkbox"/> Typhoid Fever
<input type="checkbox"/> Ulcers
<input type="checkbox"/> Whooping Cough
<input type="checkbox"/> Other _____

_____ |
|--|---|---|--|

Dr. Grimsley

VEHICLE ACCIDENT INFORMATION

Dr. Bean

Dr. Hester

Grimsley Chiropractic Services, P.C
22780 Three Notch Road, Lexington Park, MD 20653

Dr. Green

Phone: 301-737-0662 Fax: 301-737-0675

Full Name:	Date of Accident:
Time of Accident: <input type="checkbox"/> A.M <input type="checkbox"/> P.M	Accident Location:

Were You The: Driver Front Passenger Rear Passenger Pedestrian

Describe the Accident in Your Own Words:

Were You Unconscious Immediately after the Accident? Yes No If Yes, How Long?

Where Did You Feel Pain Immediately after the Accident?

Insurance & Attorney Information

Your Vehicle	Other Vehicle
Insurance Company:	Insurance Company:
Name of Policy Holder:	Name of Policy Holder:
Policy #:	Policy #:
Claim #:	Claim #:
Adjuster's Name:	Adjuster's Name:
Adjuster's Phone:	Adjuster's Phone:

Have you Retained An Attorney? Yes No

If Yes... Name: _____ Phone: _____

Address: _____

Impact Information

Vehicle & Accident Information

Did your car impact another vehicle? Yes No
 Did your car impact a structure Yes No
 Did any part of your body strike anything in the vehicle?
 Yes No
 Did police come to the accident? Yes No
 Were there witnesses? Yes No
 Was a police report filed? Yes No
 Was a violation issued? Yes No
 If yes to any question, Explain: _____

Make & Model(your vehicle): _____
 Make & Model(other vehicle): _____
 Were you wearing a seatbelt? Yes No
 Lap or Shoulder
 Did Airbags Deploy? Yes No
 Did your seat have a headrest? Yes No
 Address, City, State of Accident: _____

Nearest Intersection with Road/Street: _____

Which Direction were you headed: _____

The other vehicle: _____

Name of Driver: _____

Name of Other Driver: _____

Treatment

Did you go to the Hospital? Yes No If Yes, When: Immediately after accident The next day 2+ days

How did you get to the Hospital? Ambulance Private Transportation

Name of Hospital: _____ Doctor's Name: _____

Treatment Received: _____ Were X-rays taken: Yes No

Diagnosis: _____

Have you been able to work since this injury? Yes No How many days have you missed? _____

Before the accident were you able to work on an equal basis with others your age? Yes No

Personal Injury Cases

Please be advised that these are the steps we pursue on your behalf when filing for personal injury claims:

If you have attorney representation:

1. Must return a signed A & A within 2 weeks.
2. With a signed A & A:
 - A. Use PIP through your auto carrier.
 - B. Use health insurance if a PIP exhaustion letter is brought in.
 - C. Attorney/patient to pay all balances at time of settlement.

If you have attorney representation but do not return with a signed A & A:

- A. Use PIP through your auto carrier.
- B. Use health insurance if a PIP exhaustion letter is brought in.
- C. Pay \$25 towards the balance with each visit.
- D. Pay all balances at time of settlement.

If you do not have attorney representation:

- A. Use PIP through your auto carrier.
- B. Use health insurance if a PIP exhaustion letter is brought in.
- C. Pay \$25 towards the balance with each visit.
- D. Pay all balances after treatment is finished.

I have read and understand that I am fully responsible for all balances after insurance has been exhausted.

Patient/Guardian Signature

Date

Patient Name: _____ Date: _____

Please read instructions:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but just mark the box which most closely describes your problem.

SECTION 1- PAIN INTENSITY

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

SECTION 2 – PERSONAL CARE

(washing, dressing, etc...)

- I can look after myself normally with out causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself & I am slow & careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed. I wash with difficulty & stay in bed.

SECTION 3- LIFTING

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned. Ex. On table.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

SECTION 4- READING

- I can read as much as I want with no pain in my neck.
- I can read as much as I want to with slight pain in my neck.
- I can read as much as I want with moderate pain in my neck.
- I can't read as much as I want because of moderate pain in my neck.
- I can hardly read at all because of severe pain in my neck.
- I cannot read at all.

SECTION 5-HEADACHES

- I have no headaches at all.
- I have slight headaches which come infrequently.
- I have moderate headaches which come infrequently.
- I have moderate headaches which come frequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

SECTION 6- CONCENTRATION

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty concentrating when I want to.
- I have a lot of difficulty concentrating when I want to.
- I have a great deal of difficulty concentrating when I want to.
- I cannot concentrate at all.

SECTION 7- WORK

- I can do as much work as I want to.
- I can only do my usual work; but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.

SECTION 8- DRIVING

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I can't drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive at all because of severe pain in my neck.
- I can't drive my car at all.

SECTION 9- SLEEPING

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1hr. sleepless)
- My sleep is mildly disturbed (1-2 hrs. sleepless)
- My sleep is moderately disturbed (2-3 hrs. sleepless)
- My sleep is greatly disturbed (3-5 hrs. sleepless)
- My sleep is completely disturbed (5-7 hrs. sleepless)

SECTION 10- RECREATION

- I am able to engage in all my recreation activities with no neck Pain at all.
- I am able to engage in all my recreation activities, with some Pain in my neck.
- I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- I am able to engage in a few of my usual recreation activities because of pain in my neck.
- I can hardly do any recreation activities because of pain in my neck.
- I can't do any recreation activities at all.

Pain Scale:

Rate the severity of your pain by circling one number on the following scale

No Pain

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Excruciating Pain

Low Back Pain & Disability Questionnaire (Revised Oswestry)

Patient Name: _____ Date: _____

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but just mark the box which most closely describes your problem.

SECTION 1: PAIN INTENSITY

<input type="checkbox"/>	The pain comes & goes & is mild
<input type="checkbox"/>	The pain is mild & does not vary much
<input type="checkbox"/>	The pain comes & goes & is moderate
<input type="checkbox"/>	The pain comes & goes & is very severe
<input type="checkbox"/>	The pain is severe & does not vary much

SECTION 2: PERSONAL CARE

<input type="checkbox"/>	I would not have to change any way of washing & dressing to avoid pain
<input type="checkbox"/>	I do not normally change my way of washing or dressing even though it causes some pain
<input type="checkbox"/>	Washing & dressing increases the pain but I manage not to change my way of doing it
<input type="checkbox"/>	Washing & dressing increases the pain & I find it necessary to change my way of doing it
<input type="checkbox"/>	Because of the pain I am able to do some washing & dressing without help
<input type="checkbox"/>	Because of the pain I am unable to do any washing and dressing without help

SECTION 3: LIFTING

<input type="checkbox"/>	I can lift heavy weights without extra pain
<input type="checkbox"/>	I can lift heavy weights but it causes extra pain
<input type="checkbox"/>	Pain prevents me from lifting heavy weights off the floor
<input type="checkbox"/>	Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned
<input type="checkbox"/>	Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
<input type="checkbox"/>	I can only lift very light weights at the most

SECTION 4: WALKING

<input type="checkbox"/>	I have no pain on walking
<input type="checkbox"/>	I have some pain on walking but it does not increase with distance
<input type="checkbox"/>	I cannot walk more than 1 mile without increasing pain
<input type="checkbox"/>	I cannot walk more than 1/2 mile without increasing pain
<input type="checkbox"/>	I cannot walk more than 1/4 mile without increasing pain
<input type="checkbox"/>	I cannot walk at all without increasing pain

SECTION 5: SITTING

<input type="checkbox"/>	I can sit in any chair as long as I like
<input type="checkbox"/>	I can only sit in my favorite chair as long as I like
<input type="checkbox"/>	Pain prevents me from sitting more than 1 hour
<input type="checkbox"/>	Pain prevents me from sitting more than 1/2 hour
<input type="checkbox"/>	Pain prevents me from sitting more than 10 minutes
<input type="checkbox"/>	I avoid sitting because it increases pain right away

SECTION 6: STANDING

<input type="checkbox"/>	I can stand as long as I want without pain
<input type="checkbox"/>	I have some pain with standing but it doesn't increase with time
<input type="checkbox"/>	I can't stand for longer than 1 hour without increasing pain
<input type="checkbox"/>	I can't stand for longer than 1/2 hour without increasing pain
<input type="checkbox"/>	I can't stand for longer than 10 minutes without increasing pain
<input type="checkbox"/>	I avoid standing because it increases the pain right away

SECTION 7: SLEEPING

<input type="checkbox"/>	I have no pain in bed
<input type="checkbox"/>	I have pain in bed but it doesn't prevent me from sleeping well
<input type="checkbox"/>	Because of pain my normal night's sleep is reduced by less than 1/4
<input type="checkbox"/>	Because of pain my normal night's sleep is reduced by less than 1/2
<input type="checkbox"/>	Because of pain my normal night's sleep is reduced by less than 3/4

SECTION 8: SOCIAL LIFE

<input type="checkbox"/>	My social life is normal & give me no pain
<input type="checkbox"/>	My social life is normal but increases the degree of pain
<input type="checkbox"/>	Pain has no significant effect on my social life apart from limiting my more energetic interests (i.e. dancing, etc.)
<input type="checkbox"/>	Pain has restricted my social life and I do not go out very much
<input type="checkbox"/>	Pain has restricted my social life to my home
<input type="checkbox"/>	I have hardly any social life because of the pain

SECTION 9: TRAVELING

<input type="checkbox"/>	I have no pain when traveling
<input type="checkbox"/>	I get some pain when traveling but none of my normal forms of traveling
<input type="checkbox"/>	I get extra pain when traveling but it does not compel me to seek alternative forms of travel
<input type="checkbox"/>	I get extra pain when traveling which compels me to seek alternative forms of travel
<input type="checkbox"/>	Pain restricts all forms of travel
<input type="checkbox"/>	Pain prevents all forms of travel except that done lying down

SECTION 10: CHANGING DEGREE OF PAIN

<input type="checkbox"/>	My pain is rapidly getting better
<input type="checkbox"/>	My pain fluctuates but overall is definitely getting better
<input type="checkbox"/>	My pain seems to be getting better but improvement is slow
<input type="checkbox"/>	My pain is neither getting better nor worse
<input type="checkbox"/>	My pain is gradually worsening
<input type="checkbox"/>	My pain is rapidly worsening

PAIN SCALE: Rate the severity of your pain by circling a number on the scale below:

1 No Pain 5 Moderate Pain 10 Excruciating Pain

At Worst	1	2	3	4	5	6	7	8	9	10
At Average	1	2	3	4	5	6	7	8	9	10
At Best	1	2	3	4	5	6	7	8	9	10

CONSENT TO CHIROPRACTIC EXAMINATION AND CARE

I hereby authorize Grimsley Chiropractic Services and its licensed doctors and assistants, based on my complaints and the history I have provided, to undertake an examination and provide an evaluation and treatment plan which may include chiropractic adjustments and other tests and procedures considered therapeutically appropriate. I also wish to rely on Grimsley Chiropractic doctors to make those decisions about my care, based on the facts then known that they believe are in my best interest.

The nature and purpose of the chiropractic examination and evaluation, the chiropractic adjustments and the other procedures that may be recommended during the course of my care have been explained and described to my satisfaction.

By signing below I acknowledge my consent to be examined:

Patient's Printed Name

Patient's Signature

Date

The specifics of the doctor's recommendation will be further explained during a Report of Findings following your examination and any subsequent examinations and significant changes in your diagnosis or treatment plan.

Based on current findings, Grimsley Chiropractic doctors have discussed my diagnosis and treatment plan, the benefits and expected improvement with the proposed treatment and the reasonable alternatives to the proposed treatment. They have also explained the cost of my proposed care (or provided me with a current fee schedule) and to the extent practicable the costs of reasonable alternatives to the proposed treatment.

To aid the understanding of my condition and the reasons for the proposed course of care, Grimsley Chiropractic Services has provided me with the information and Grimsley Chiropractic doctors have answered my questions regarding the planned treatments and course of care that I will receive. The doctors of Grimsley Chiropractic Services have also explained that my diagnosis and treatments may change during the course of care and that they will advise me of material changes in my diagnosis and treatment options and answer any additional questions that I may have at any time.

I have been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of rare possible hazards and complications which may be encountered or result during the course of care. These include, but are not limited to, fractures, disk injuries, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

I understand and accept that:

1. I have the right to withdraw from or discontinue treatment at any time and that the Practice doctors will advise me of any material risks in this regard.
2. That neither the practice of chiropractic nor the medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor during the course of my care.
3. That it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications or an undesirable result does not necessarily indicate an error in judgment or treatment.
4. The Practice does not guarantee as to results with respect any course of care or treatment.
5. My care and treatment will not be observed or recorded for any non-therapeutic purpose without my consent.

I have read this Consent (or have had it read to me) and have also had an opportunity to ask questions about the Consent and understand to my satisfaction the care and treatment I may receive. My signature below acknowledges my consent to the examination, evaluation and proposed course of care and treatments by the Practice.

Patient's Printed Name

Patient's Signature

Date

Doctor's Notes:

Signature of Doctor

Date

Notice of Privacy Practices
Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Health Record:

A record is made each time you visit a hospital, physician, or other health care provider. Your symptoms, examination and test results, diagnosis, treatment, and a plan for future care are recorded. This information is most often referred to as your "health or medical record", and serves as a basis for planning our care and treatment. It also serves as a means of communication among any and all other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will help you to ensure accuracy and enable you to relate to who, what, when, where, and why others may be allowed to access your health information. This effort is being made to assist you in making informed decisions before authorizing the disclosure of your medical information to others. Use or disclosure of your health information will follow the more stringent of State or Federal laws.

Understanding Your Health Information Rights:

Your health record is the physical property of the health care practitioner or facility that compiled it but the content is about you, and therefore belongs to you. You have the right to request restrictions on certain uses and disclosures of your information, and to request amendments be made to your health record. Your rights include being able to review or obtain a paper copy of your health information, and to be given an account of all disclosures. You may also request communications of your health record be made by alternative means or to alternative locations. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information.

Our Responsibilities:

This office is required to maintain the privacy of your health information and to provide you with notice of our legal commitment and privacy practices with respect to the information we collect and maintain about you. This office is required to abide by the terms of this notice and to notify you if we are unable to grant your requested restrictions or reasonable desires to communicate your health information by alternative means or to alternative locations.

This office reserves the right to changes it practices and effect new provisions that enhance the privacy standards of all patient medical information. In the event that changes are made, this office will notify you at the current address provided on your medical file. If applicable, this office will post changes on our website that provides information about our customer service and/or benefits. Other than the reason described in this notice, this office agrees not to use or disclose your health information without your authorization.

To receive additional information or to report a problem:

For further explanation of this notice you may contact our Privacy Officer at (301) 737-0662. If you believe your privacy rights have been violated, you have the right to file a complaint with this office by contacting the individual above, or by contacting the Secretary of Health and Human Services, with no fear of retaliation by this office.

Your Health Information Will Be Used For Treatment, Payment, and Health Care Operations:

Treatment--Information obtained by your health practitioner in this office will be recorded in your medical record and used to determine the course of treatment that should work best for you. This consists of your physician recording his/her own expectations and those others involved in providing your care such as his/her physician assistant, nurse, or medical assistant. The sharing of your health information may progress to others involved in your care, such as specialty physicians or lab technicians.

Payment--Your health care information will be used in order to receive payment for services rendered by this office. A bill may be sent to you or a third-party payer with accompanying documentation that identifies you, your diagnosis, procedures performed, and supplies used.

Health Care Operations---The medical staff in this office will use your health information to assess the care provided and the outcome of your care compare to others like it. Your information may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide.

(continued over)

Business Associates---Some or all of your health information may be subject to disclosure through contracts for services to assist this office in providing health care. For example, it may be necessary to obtain specialized assistance to process certain laboratory tests or radiology images. To protect our health information, we require these Business Associates to follow the same standards held by this office through terms detailed in a written agreement.

Notification---Your health care record may be used to notify or assist family members, personal representatives, or other persons responsible for your care to enhance your well-being or whereabouts.

Communications with Family---Using best judgment, a family member, or a close personal friend, identified by you, may be given information relevant to your care and/or recovery.

Upon Your Death--- Your health information may be disclosed consistent with laws governing estate and post-mortem personal matters. Generally, your health information may be disclosed to your personal representative as designated by you and certified by the State and to Funeral Directors with laws governing mortician services.

Organ Procurement Organization---Your health information may be disclosed consistent governing entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation or transplant.

Marketing---This office reserves the right to contact you with information about treatment alternatives and other health related benefits that may be appropriate to you.

Appointment Reminders---This office reserves the right to contact you with appointment reminders through an automated system, by our staff, or via U.S. Postal Service.

Phone Contact---This office reserves the right to contact you via the telephone for such things as test result notification. We may leave a generic message on your answering machine, or with the person answering the phone concerning the nature of the call along with a request that you call us for more specific details.

Research---Your information will be disclosed to researchers upon institutional Review Board approval and upon the assurance that established protocol to ensure the privacy of your health information has been obtained.

Food and Drug Administration (FDA)--- This office is required by law to disclose health information to the FDA related to any adverse effects of food, supplements, products, and product defects for surveillance to enable products recalls, repairs, or replacements.

Workers Compensation---This office will release information to the extent authorized by law in matters of Workers' Compensation.

Public Health---This office is required by law to disclose health information to public health and/or legal authorities charged with tracking reports or birth and morbidity. This office is further required by law to report communicable disease, injury, or disability.

Correction Facilities---This office will release medical information on incarcerated individuals to Correctional Agents or Institutions for the necessary welfare of the individual or for the health and safety of other individuals. The rights outlined in this Notice of Privacy Practices will not be extended to incarcerated individuals.

Law Enforcement--- (1) Your health information will be disclosed for law enforcement purposes as required under State Law or in response to a valid subpoena. (2) Provisions of Federal Law permit the disclosure of your health information to appropriate health oversight agencies, public health authorities, or attorneys in the event that a staff member or business associate of this office believes in good faith that there has been unlawful conduct or violations of professional or clinical standards that may endanger one or more parties, workers, or the general public.

NOTICE OF PRIVACY PRACTICES AVAILABILITY: The terms described in this notice will be posed where registration occurs. All individuals receiving care will be given a hard copy

Patient's Comments:

Signature of Patient or Legal Representative

Date

(Description of Legal Representative's Attorney)

AUTHORIZATION TO PAY CHIROPRACTOR

I hereby authorize the _____ Insurance Company to pay by check made out and mailed directly to:

Henry Chiropractic of St. Mary's
22780 Three Notch Road
Lexington Park, MD 20653

the medical and surgical expense benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for Professional Services rendered. This payment will not exceed my indebtedness to the above mentioned assignee, and I agree to pay, in a current manner, any balance of said Professional Service charges over and above this insurance payment.

If my current policy prohibits direct payment to doctor, then I hereby authorize you to make the check to me and mail it as follows:

Henry Chiropractic of St. Mary's
22780 Three Notch Road
Lexington Park, MD 20653

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Date _____

(Signature of Policyholder)

(Witness)

Missed Appointments

Effective November 1st, 2016, we will allow 2 missed appointments per year before charging \$40.00 to your account.

In other words, you get 2 "free" no show appointments per calendar year. The appointment will not be charged if you call to cancel or reschedule at least 4 hours prior to the appointment time or left a message on our voicemail.

Thank you for your consideration to our other patients who can fill in during these missed slots.

Print Name: _____

Signature: _____ *Date:* _____

HENRY CHIROPRACTIC OF ST. MARY'S



ASSIGNMENT AND AUTHORIZATION

You are hereby authorized to disclose and/or furnish my attorney(s) with any and all medical information, bills, and/or records in your possession which they request in reference to any illnesses and injuries which I have suffered.

I further, irrevocably assign to you, and authorize and direct said attorneys to pay from the proceeds of any recovery in my case all reasonable fees for services provided by you, including fees for preparation and testimony, as a result of the injury or condition heretofore mentioned. I understand that this in no way relieves me of my personal primary obligation to pay for such services and that the signing of this form does not prohibit customary billing by you. All bills shall be paid promptly in the usual manner.

It is further understood that the statute of limitations in this state is three (3) years from the time said services were last performed and I further understand that because of long delays in the trial dockets, many cases are not tried or settled until a date which is beyond three (3) years after the last service was performed. In view of this, I hereby agree that the statute of limitations with respect to any claim for services mentioned above will not begin to run until there is a denial in writing by me of any balance claimed to be due and owing to you by me.

PATIENT'S SIGNATURE : _____

ADDRESS : _____

RELATIONSHIP TO PATIENT : _____

WITNESS : _____ **DATE :** _____

THE UNDERSIGNED ATTORNEY FOR THE PATIENT REFERRED TO ABOVE HEREBY AGREES TO COMPLY FULLY WITH THE FOREGOING "AUTHORIZATION AND ASSIGNMENT" AND AGREES TO ADVISE NAMED ASSIGNEE IN WRITING THE STATUS OF THE CLAIM OF THE PATIENT WITHIN TEN (10) DAYS OF THE REQUEST, AND AGREES TO NOTIFY THE ASSIGNEE IF THE ATTORNEY CEASES TO REPRESENT THIS PATIENT AND/OR IF THE CLAIM IS DROPPED OR DENIED.

ATTORNEY